MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: () HCP (x) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Liberty Mutual Insurance Co. 2875 Browns Bridge Rd. Gainsville, GA 30503	MDR Tracking No.: M4-04-2916-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address RX Solutions P.O. Box 16688 Tampa, FL 33667	Date of Injury: Employer's Name: Thorpe Corporation Insurance Carrier's No.: 973404880

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
02/13/02	02/13/03	63660 & 76000	$784.98	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary states in part, "…We are filing a notice of dispute against provider, RX Solutions, regarding a refund due in the amount of $784.98 for date of service: 2/13/03. This were paid and billed in error…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary not submitted.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The requestor submitted a HCFA-1500 for the disputed date of service; however, the HCFA was not date stamped as required by Rule 133.300(b). The requestor submitted an EOB showing an audit date of 02/13/03; the date of the request for refund was 07/09/03; therefore, per Rule 133.304(a) and (b)(3) the Requestor did not request the refund within the 45th day after the Requestor received a complete medical bill. Refund Reimbursement is not recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

Ordered by:

	Marguerite Foster	02/17/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____